Application Completion Instructions 2007

Purpose

This chapter explains in detail how to complete the joint Healthy Families and Medi-Cal for Families mail-in application.

Mail-In Application Booklet

The joint Healthy Families and Medi-Cal for Families mail-in application booklet includes the four-page application, basic instructions for completion, and a pre-addressed, postage-paid envelope. For further information, you can look at the *"Need Help?,"* "*Family Size and Income,*" "*Pregnant?,*" and "*Other Questions*" sections on pages 3 – 6 of the application. These sections contain answers to frequently asked questions. The application is available in the following twelve languages

- Arabic
- Armenian
- Chinese
- English
- Farsi
- Hmong
- Khmer (Cambodian)
- Korean
- Russian
- Spanish
- Tagalog
- Vietnamese

The application is organized with numbered questions. It is important that the application be completely and legibly filled out when submitted. Missing information or information which cannot be read can delay processing of the application.

Review of Applications

All mailed applications are screened by Single Point of Entry (SPE) to determine if a child is eligible for no-cost Medi-Cal or currently receiving no-cost Medi-Cal. In certain circumstances, the county Department of Social Services may determine that the children are eligible for no-cost Medi-Cal even though they appeared to be eligible for the Healthy Families Program. It is important that CAAs explain this to families. See Chapter 4 (*Family Size and Income Determinations*) for more information.

Some examples where this could occur include the following

- Children can have separate incomes that are counted, i.e., child support or Social Security
- Children under 18 have their own children and live with their own parents
- Stepparents or unmarried parents are part of the family size

- Pregnant teenager applying for the health care coverage

In these situations, the children's natural or adoptive parents and the children's own incomes are used to determine the families' income. The income of stepparents, foster parents, caretaker relatives, and siblings is not used.

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Application

Please fill out all 4 pages of this form. Print clearly.
Use black or blue ink only. Mail your completed form to:

Healthy Families/Medi-Cal
P.O. Box 138005
Sacramento, CA 95813-9984

HEALTHY FAMILIES
MEDI-CAL FOR FAMILIES

Need Help?
Call: 1-800-880-5305

Tell us about the family member filling out this form.

① Last Name | First Name | Middle Initial | Date of Birth (mo/day/yr) ___/___/___

② Home Address *(Number and Street)* **Do NOT use a P.O. Box – unless homeless** | Apt. # | Home Phone # ( )

③ City | County | Zip Code | Work Phone # ( )

④ Mailing Address *(if different from above)* or P.O. Box | Apt. # | Message or Cell Phone #

⑤ City | Zip Code | E-mail Address *(Optional)*

⑥ What language do you want us to speak to you in? _____

⑦ What language should we write to you in? _____

Tell us who you are applying for. *(If more than 3 children, photocopy pages A1 and A2 to list other children.)*

	Child 1	Child 2	Child 3	Pregnant Woman	Unborn Child
⑧ Name – Last					Pregnant women in Medi-Cal or AIM: do not fill out this part.
⑧ Name – First					
⑧ Name – Middle					
⑨ Name on birth certificate (if different from name above) – Last					☐ Check here to apply for Healthy Families for your baby before he/she is born.
⑨ Name on birth certificate – First					You must: • Be at least 6 months pregnant, • Send proof of pregnancy from your doctor or clinic with the application, and • Send proof of birth when the baby is born.
⑨ Name on birth certificate – Middle					
⑩ Is this child living away from home?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		
⑪ Home address (If different from home address in ②)					
⑫ Mailing address (If different from mailing address in ④)					
⑬ Date of Birth	___/___/___ mo day yr	___/___/___ mo day yr	___/___/___ mo day yr	___/___/___ mo day yr	*(More information on page 5.)*
⑭ Relationship to person in ①	☐ My child ☐ My stepchild ☐ Other: _____	☐ My child ☐ My stepchild ☐ Other: _____	☐ My child ☐ My stepchild ☐ Other: _____	Baby's Due Date: ___/___/___	
⑮ Gender	☐ Boy ☐ Girl	☐ Boy ☐ Girl	☐ Boy ☐ Girl	Number of babies expected: _____	

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		Child 1	Child 2	Child 3	Pregnant Woman	Unborn Child
16	Ethnicity – *Optional* *(For more information, see page 6.)*					
17	Birthplace County:					
	State:					
	Or foreign country:					
18	Social Security No. *(For more information, see pages 6 and 7.)*					
		This is optional if you are applying for Healthy Families or for emergency or pregnancy services.				
19	U.S. Citizen or National? *(More information on pages 3 and 7.)*	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	
	If No, date arrived in the U.S.	____/____/____ mo day yr	____/____/____ mo day yr	____/____/____ mo day yr	____/____/____ mo day yr	
20	Medi-Cal benefits card number (BIC), if you have it:					
21	Does this person have other health, dental or vision insurance?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	
		Even if you have other health insurance, Medi-Cal may cover what your other insurance does not.				
22	Was this child covered by a health plan paid by your employer in the last 3 months? *(For more information, see page 6.)*	☐No ☐Yes *(If yes, write the date it ended and check reason below.)* ____/____/____ mo day yr Health coverage ended because: ☐Lost job ☐Job status changed ☐Moved and no insurance available ☐All employees' benefits ended ☐Death, divorce or legal separation ☐COBRA ended ☐Other__________	☐No ☐Yes *(If yes, write the date it ended and check reason below.)* ____/____/____ mo day yr Health coverage ended because: ☐Lost job ☐Job status changed ☐Moved and no insurance available ☐All employees' benefits ended ☐Death, divorce or legal separation ☐COBRA ended ☐Other__________	☐No ☐Yes *(If yes, write the date it ended and check reason below.)* ____/____/____ mo day yr Health coverage ended because: ☐Lost job ☐Job status changed ☐Moved and no insurance available ☐All employees' benefits ended ☐Death, divorce or legal separation ☐COBRA ended ☐Other__________		
23	Does this person want to apply for Medi-Cal for medical expenses in the last 3 months? *(For more information, see page 6.)*	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	
		Medi-Cal may cover medical expenses for past 3 months.				
24	Mother's Name: Last					
	First					
	Does this child live with the mother?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
25	Father's Name: Last					
	First					
	Does this child live with the father?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		☐Yes ☐No

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If you need more space, make a copy of this page or attach another sheet.

Family Size List **all** other family members who live in the home. Include children under 21, stepparents, and the spouse of any teenager or pregnant woman who lives in the home. Do **not** list aunts, uncles, nieces, nephews, or grandparents. *(For more information, see page 4.)*

	Name	Gender	Date of Birth	How is this person related to the person in ①?
㉖		☐M ☐F	____/____/____ mo day yr	☐Child ☐Boyfriend ☐Spouse ☐Stepchild ☐Girlfriend ☐Other _____
㉗		☐M ☐F	____/____/____ mo day yr	☐Child ☐Boyfriend ☐Spouse ☐Stepchild ☐Girlfriend ☐Other _____
㉘		☐M ☐F	____/____/____ mo day yr	☐Child ☐Boyfriend ☐Spouse ☐Stepchild ☐Girlfriend ☐Other _____

㉙ Is any person in the home pregnant? . . . . . ☐ Yes ☐ No

*If yes, who?*_____ *How many babies is she expecting?*_____ *Due Date:* ____/____/____ mo day yr

Family Income List the income of **every** person listed in this application. Include child support and spousal support **received**. *(Use a separate line for each source of income.)*

	Name of person with income *(Children who are in school do not have to list their income from a job.)*	Source of Income *(job, social security, pension, etc.)*	How often is income received? *(Weekly, biweekly, monthly)*	How much is the income? *(total gross income)*	Social Security Number *(Optional)*
㉚				$	
㉛				$	
㉜				$	
㉝				$	
㉞				$	

Expenses List the monthly expenses of the person in ① and the people listed above.

㉟ Child Day Care or Disabled Dependent Care

For *(child or dependent's name)*:_____ Age:_____ Amount paid:_____

For *(child or dependent's name)*:_____ Age:_____ Amount paid:_____

For *(child or dependent's name)*:_____ Age:_____ Amount paid:_____

㊱ Court-ordered child support

Paid to:_____ Paid by:_____ Amount paid:_____

Paid to:_____ Paid by:_____ Amount paid:_____

㊲ Court-ordered spousal support

Paid to:_____ Paid by:_____ Amount paid:_____

Household Information

㊳ Does the person in ①, anyone listed above, or any other person in the home want Medi-Cal? . . . ☐ Yes ☐ No

*If yes, who?*_____ *(If you answer Yes, we will contact you.)*

㊴ Does any person in the home have a physical, mental, emotional or developmental disability and want Medi-Cal? . . . . . ☐ Yes ☐ No

*If yes, who?*_____ *(If you answer Yes, we will contact you to see if you qualify.)*

㊵ Is any person applying for coverage involved in a lawsuit because of an injury or accident?

(For more information, see page 6.) . . . . . ☐ Yes ☐ No

㊶ Is there more than one car in the household? *(Optional)*. . . . . ☐ Yes ☐ No

㊷ Is there more than $3,150 in household bank accounts? *(Optional)* . . . . . ☐ Yes ☐ No

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The health care programs may share your information unless you check below:

(43) ☐ We will send your application to Healthy Kids or a similar county program if your child does not qualify for full Medi-Cal or Healthy Families. If you do not want us to send it, check here. *(For more information, see page 6.)*

(44) ☐ Medi-Cal will share your child's application with Healthy Families if your child no longer qualifies for free Medi-Cal in the future. If you do not want us to send it, check here.

Choose your Healthy Families plans:

Write the name or code of the plans you want below. To learn more about what plans are available, see the Healthy Families Handbook or call: **1-800-880-5305.** Or visit: **www.healthyfamilies.ca.gov**

(45) Health Plan _____ (Name) _____ (Code)

(46) Doctor or Clinic *(Optional)* _____ (Name) _____ (Code)

(47) Dental Plan _____ (Name) _____ (Code)

(48) Dentist or Clinic *(Optional)* _____ (Name) _____ (Code)

(49) Vision Plan _____ (Name) _____ (Code)

(50) Eye Doctor or Clinic *(Optional)* _____ (Name) _____ (Code)

Check all boxes that describe you:

(51) ☐ Native American Indian ☐ Forestry worker ☐ Agricultural worker ☐ Working in Fishing

If you checked any of these boxes, you may qualify for the Special Population Plan that covers your child in any California county. Look for the Plan Code for this special plan in your Healthy Families Handbook or at www.healthyfamilies.ca.gov.

Are you (or the child applying for coverage) a Native American Indian or Alaska Native who wants free Healthy Families health care?

(52) ☐ Yes ☐ No *If yes, see page 6.*

Healthy Families Plan Disputes

Each plan has its own rules for resolving disputes about the delivery of services and other matters. Some plans say you must use binding arbitration for disputes; others do not. Some plans say that claims for malpractice must be decided by binding arbitration; others do not. If the plan you choose requires binding arbitration, you are giving up your right to a jury trial and cannot have the dispute decided in court. To find out more about how a plan resolves disputes, you can call the plan or look in the HFP Handbook. Or go to: www.healthyfamilies.ca.gov.

Declaration and Signature *(Required)*

I declare under penalty of perjury under California state law that I have read this application, the answers provided, and the documents enclosed and, to the best of my knowledge, they are correct and true. I have read and understand the Notices, and I am making the Declarations on page 7.

Applicant signs here: _____ Date: _____

Witness signs here *(If applicant signed with a mark):* _____ Date: _____

Authorized Representative *(If any):* _____ Date: _____

Fill out below ONLY if a Certified Application Assistant (CAA) helped you fill out this form.

☐ Check this box and sign below to allow Healthy Families and Medi-Cal to speak to a representative of the Enrollment Entity (EE) listed below about the status of this Application. This permission ends when the program mails you its decision on this Application.

I certify the CAA listed below helped me complete this application. This CAA helped me for free.

Applicant Signature: _____ Date: _____

CAA# _____ EE# _____

CAA Signature: _____ Date: _____

The state will not reimburse the EE unless the CAA fills out this section completely and correctly when the application is submitted.

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Application Page A1

Page A1 of the application requests information about the applicant who is applying for Medi-Cal or Healthy Families.

Applicant Information

The applicant is the person who is completing the application for himself or herself, a child, pregnant woman, or unborn child. The child must live with the applicant unless he/she is the natural or adoptive parent and wishes to apply only for the Healthy Familes Program for the children. See Chapter 7 (*Healthy Families Program)* for more information about an absent parent applying for their child.

Applicants include the following people

- Natural or adoptive parents (whether they live with the child or not)
- Caretaker relatives, such as grandparents, aunts, uncles, cousins, siblings, or other family members with whom the child lives and who exercise the primary care and control of the child
- Legal Guardians who have a court order or other legal status that gives authority for health care and other decisions. A copy of a court order does NOT need to be submitted with the application
- Foster parents
- Stepparents
- A person applying for coverage on his or her own behalf (including a pregnant woman)
- Children under age 18 may apply for coverage on their own if they are not living with a parent or caretaker relative, legal guardian, foster parent, or stepparent

NOTE: Minor parents (age 18 or younger) who have their own children may complete an application for their children. However, if minor parents live with their own parents and want coverage for themselves, their parents must apply for them.

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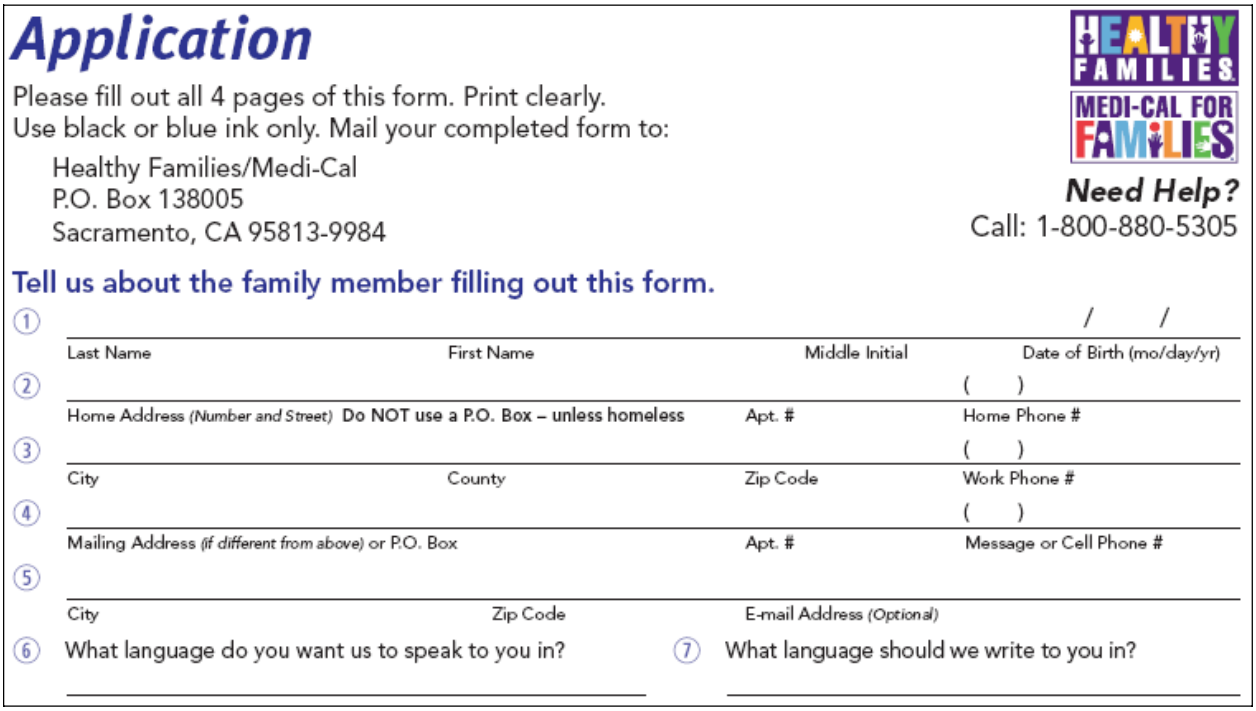

Application

Please fill out all 4 pages of this form. Print clearly.
Use black or blue ink only. Mail your completed form to:

Healthy Families/Medi-Cal
P.O. Box 138005
Sacramento, CA 95813-9984

HEALTHY FAMILIES
MEDI-CAL FOR FAMILIES

Need Help?
Call: 1-800-880-5305

Tell us about the family member filling out this form.

1 Last Name | First Name | Middle Initial | Date of Birth (mo/day/yr) / /

2 Home Address (Number and Street) Do NOT use a P.O. Box – unless homeless | Apt. # | Home Phone # ( )

3 City | County | Zip Code | Work Phone # ( )

4 Mailing Address (if different from above) or P.O. Box | Apt. # | Message or Cell Phone # ( )

5 City | Zip Code | E-mail Address (Optional)

6 What language do you want us to speak to you in?

7 What language should we write to you in?

Questions 1 - 7

1. Applicant

   - List the last name, first name, and middle initial of the applicant
   - Enter the date of birth of the applicant as shown: Month/Day/Year

2. Home Address

   - Enter the street address, road, rural route or other physical description where the applicant lives

   NOTE: Do not enter a P.O. Box unless the applicant has no home address (for example the applicant is homeless or lives in a rural area where only P.O. boxes are available).

   Apartment Number

   - Enter the apartment or unit number (or letter) if the applicant lives in an apartment
   - Leave blank if the applicant does not live in an apartment

   Home Phone Number

   - Enter the applicant's home phone number including the area code
   - Leave blank if the applicant does not have a home phone number

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NOTE: Applicants should provide at least one phone number on the application so they can be contacted for clarification or when additional information is required. This could also be a work, home, and/or cell, or message phone number (See Questions 2, 3, and 4).

3. City

- Enter the city in which the applicant lives

County

- Enter the county in which the applicant lives

Zip Code

- Enter the zip code in which the applicant lives

Work Phone Number

- Enter the applicant's work phone number
- Leave blank if the applicant does not have a work phone number

4. Mailing Address

- Enter the applicant's mailing address if it is different from the home address provided in Question 2
- If the applicant has a P.O. Box, list it here
- Leave blank if the mailing address is the same as the home address

Apartment Number

- Enter the apartment or unit number (or letter) if the applicant lives in an apartment
- Leave blank if the applicant does not live in an apartment

Message or Cell Phone Number

- Enter the message or cell phone number
- Leave blank if the applicant does not have a message or cell phone number

5. City

- Enter the city of the applicant's mailing address
- Leave blank if the mailing address is the same as the home address

Zip Code

- Enter the zip code of the mailing address
- Leave blank if the mailing address is the same as the home address

E-Mail Address

- Enter the applicant's e-mail address. This information is optional

6. Language the applicant wants us to speak to them in

   - Enter the language which the applicant speaks best. This information is used when the applicant needs to be contacted by telephone. Representatives are available to assist in many languages; including, but not limited to:

Arabic	Hmong	Russian
Armenian	Khmer	Spanish
Cantonese	Korean	Tagalog
English	Mandarin	Ukrainian
Farsi	Punji/Hindi	Vietnamese

7. Language the applicant wants us to write to them in

   - Enter the language in which the applicant reads best
   - This information is used when any written correspondence needs to be sent to the applicant

Application Page A1

Information about Children and the Pregnant Woman

This section asks for information about children under age 19, an unborn child, and/or the pregnant woman who wants health coverage.

The application has columns for three children plus a column for a pregnant woman and an unborn child.

Applicants can apply for the Healthy Families Program for an unborn child up to 3 months before the child's expected date of birth. If the family income is within the eligibility level for "Child Birth Up to Age 1" for the Healthy Families Program (between 200% and 250% of the Federal Income Guidelines), the unborn child may be eligible for the Healthy Families Program. In this case, use the "Unborn Child" column, checking the box to indicate this is an unborn child.

Questions 8 - 15

Tell us who you are applying for. *(If more than 3 children, photocopy pages A1 and A2 to list other children.)*

		Child 1	Child 2	Child 3	Pregnant Woman	Unborn Child
⑧ Name	Last					Pregnant women in Medi-Cal or AIM: do not fill out this part.
	First					
	Middle					
⑨ Name on birth certificate (If different from name above)	Last					☐ Check here to apply for Healthy Families for your baby before he/she is born.
	First					
	Middle					
⑩ Is this child living away from home?		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		You must: • Be at least 6 months pregnant, • Send proof of pregnancy from your doctor or clinic with the application, and • Send proof of birth when the baby is born.
⑪ Home address (If different from home address in ②)						
⑫ Mailing address (If different from mailing address in ④)						
⑬ Date of Birth		____/____/____ mo day yr	____/____/____ mo day yr	____/____/____ mo day yr	____/____/____ mo day yr	*(More information on page 5.)*
⑭ Relationship to person in ①		☐ My child ☐ My stepchild ☐ Other: _____	☐ My child ☐ My stepchild ☐ Other: _____	☐ My child ☐ My stepchild ☐ Other: _____	Baby's Due Date: ____/____/____	
⑮ Gender		☐ Boy ☐ Girl	☐ Boy ☐ Girl	☐ Boy ☐ Girl	Number of babies expected: _____	

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Application Page A1

Questions 8 through 15 MUST be answered for each child and/or pregnant woman requesting coverage.

Questions 8 – 15

8. Name

   - List the name (last, first, middle) of each child and/or pregnant woman who wants health coverage

9. Name on Birth Certificate

   - List the name exactly as it appears on each child's and or pregnant woman's birth certificate
   - Leave this question blank if the name on the birth certificate is the same as in Question 8

10. Is this child living away from home?

    - Indicate whether the child is currently living away from the home

11. Home address

    - Enter the child's home address if the child does not live with the applicant
    - The child and/or pregnant woman must live in California to be eligible for either Medi-Cal or the Healthy Families Program

12. Mailing address

    - Enter the child's mailing address if different from the applicant's

13. Date of Birth

    - Enter the birth date of each child and/or pregnant woman as shown: Month/Day/Year

14. Relationship to person in (1)

    - Check the box that best describes the relationship of the child to the person in Question 1 (i.e. the person who is completing the application). If the person being applied for is not the child or stepchild, please write in the type of relationship under "Other." This would include relationships such as grandchild, nephew, niece, cousin, ward (e.g., a child under the care of a guardian), etc. It is important to accurately identify the relationship because this information is used to determine family size and financial responsibility

Application Page A1

Baby's Due Date

- If there is a pregnant woman applying for coverage, indicate her expected date of delivery as shown: Month/Day/Year

15. Gender of child being applied for

- If pregnant woman is applying
    - Number of babies expected
- Each unborn baby carried by a pregnant woman is counted in the family size. If the pregnant woman is carrying more than one baby (e.g., twins), indicate the number of expected babies. The pregnant woman will need to provide proof of the expected number of babies

Application Page A2

Page A2 of the application obtains information about the children and/or pregnant woman who want to be enrolled in health care coverage.

Questions 16 through 25 MUST be answered for each child and/or pregnant woman requesting coverage. Questions 24 and 25 must be answered for the unborn child.

<u>Questions 16 –25</u>

	Child 1	Child 2	Child 3	Pregnant Woman	Unborn Child
(16) Ethnicity – *Optional* *(For more information, see page 6.)*					
(17) Birthplace — County:					
State:					
Or foreign country:					
(18) Social Security No. *(For more information, see pages 6 and 7.)*					
This is optional if you are applying for Healthy Families or for emergency or pregnancy services.					
(19) U.S. Citizen or National? *(More information on pages 3 and 7.)*	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	
If No, date arrived in the U.S.	___/___/___ mo day yr	___/___/___ mo day yr	___/___/___ mo day yr	___/___/___ mo day yr	
(20) Medi-Cal benefits card number (BIC), if you have it:					
(21) Does this person have other health, dental or vision insurance?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	
Even if you have other health insurance, Medi-Cal may cover what your other insurance does not.					
(22) Was this child covered by a health plan paid by your employer in the last 3 months? *(For more information, see page 6.)*	☐No ☐Yes *(If yes, write the date it ended and check reason below.)* ___/___/___ mo day yr Health coverage ended because: ☐Lost job ☐Job status changed ☐Moved and no insurance available ☐All employees' benefits ended ☐Death, divorce or legal separation ☐COBRA ended ☐Other______	☐No ☐Yes *(If yes, write the date it ended and check reason below.)* ___/___/___ mo day yr Health coverage ended because: ☐Lost job ☐Job status changed ☐Moved and no insurance available ☐All employees' benefits ended ☐Death, divorce or legal separation ☐COBRA ended ☐Other______	☐No ☐Yes *(If yes, write the date it ended and check reason below.)* ___/___/___ mo day yr Health coverage ended because: ☐Lost job ☐Job status changed ☐Moved and no insurance available ☐All employees' benefits ended ☐Death, divorce or legal separation ☐COBRA ended ☐Other______		
(23) Does this person want to apply for Medi-Cal for medical expenses in the last 3 months? *(For more information, see page 6.)*	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	
Medi-Cal may cover medical expenses for past 3 months.					
(24) Mother's Name: *Last*					
First					
Does this child live with the mother?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
(25) Father's Name: *Last*					
First					
Does this child live with the father?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		☐Yes ☐No

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Application Page A2

16. Ethnicity

- Indicate the ethnicity of each child, pregnant woman, or unborn child

  Here is a list that may help:

Alaska Native	Hispanic
Amerasian	Japanese
Asian Indian	Korean
Black/African American	Laotian
Cambodian	Native American Indian
Chinese	Other Asian
Filipino	Samoan
Guamanian	Vietnamese
Hawaiian	White
Other	

17. Birthplace

- Enter the county if the child and/or pregnant woman was born in California
- Identify the state if the child and/or pregnant woman was born in the U.S. but outside of California
- List the country of birth if the child and/or pregnant woman was born outside of the U.S.

18. Social Security Number

- Enter the Social Security number of each child and/or pregnant woman when applying for Medi-Cal. If the applicant does not provide Social Security numbers when he/she completes the application, the application will still be forwarded to the county Department of Social Services. The county Department of Social Services will contact the applicant for the child's and/or pregnant woman's Social Security numbers

  NOTE: Social Security numbers are not required by the Healthy Families Program. For more information refer to the page 6 of the application "*Other Questions*" and page 7 of the application "*Healthy Families Notices and Medi-Cal Notices*."

19. U.S. Citizen or National

- Indicate if the child and/or pregnant woman are U.S. Citizens or Nationals
- U.S. Citizens and Nationals include those individuals who were:
  - Born in the U.S.
  - Native Americans born in Canada
  - Born in Puerto Rico

- Born in the Northern Mariana Islands
- Born in Guam
- Born in the Virgin Islands of the U.S. (St. Thomas, St. John, and St. Croix)
- Born in Swain's Island
- Born in America Samoa
- Individuals who are Naturalized Citizens
- Individuals who have Acquired Citizenship or Derived Citizenship

- If the "no" box is checked, enter the date of entry into the U.S. See Chapter 6 (*Medi-Cal Program)* and Chapter 7 (*Healthy Families Program)* in the Reference Manual for more information about the different types of immigration statuses and confidentiality

NOTE: For more information refer to the page 3 of the application *"Need Help?"* and page 7 of the application "*Healthy Families Notices and Medi-Cal Notices*."

20. Medi-Cal benefits card number

- Enter the child and/or pregnant woman's Medi-Cal benefits card number (BIC) if you have it

  See Chapter 6 (*Medi-Cal Program*) in the Reference Manual for more information and an example of a BIC.

21. Other Insurance Dental or Vision Insurance

- Indicate whether the child and/or pregnant woman has other health, dental, or vision insurance

NOTE: Even if the child and/or pregnant woman has other health insurance, Medi-Cal may cover what the other insurance does not.

22. Employer Sponsored Insurance

- If the child was covered by employer sponsored health insurance in the past three months, check "yes." If not, check "no"
- If "yes" is checked, indicate the date the health insurance ended as shown: Month/Day/Year
- If "yes" is checked, also indicate the reason the health insurance ended. If no reason listed fits the reasons already shown, check "Other" and write in the reason

23. Applying for retro-active Medi-Cal

- If the child and/or pregnant woman has medical expenses from the past three months and would like to apply for Medi-Cal to cover the expenses, check "yes." If not, check "no"

Medi-Cal can pay for past medical bills if the applicants or children have medical expenses during the three months before the date of application (when the application is

received at SPE). This is called retroactive Medi-Cal. See Chapter 6 (*Medi-Cal Program*) for more information.

When the county Department of Social Services receives the applications, it will contact the applicants to obtain the information needed for the month(s) coverage is requested.

NOTE: Children who are eligible for Healthy Families may be eligible for assistance from Medi-Cal with past medical expenses.

If it is close to the end of the month and families are requesting retroactive Medi-Cal for the earliest month possible, it is best for the applicant to go to the county Department of Social Services to complete the application for retroactive (past) medical expenses instead of using the mail-in application. See Chapter 6 (*Medi-Cal Program*) for more information and an example.

24. Mother's Name

- Enter the last name and first name of the child's and/or unborn's mother
- Do not list a child's stepmother
- If the child lives with the mother, check "yes," if not, check "no"

25. Father's Name

- Enter the last name and first name of the child's and/or unborn's father
- Do not list child's stepfather
- If the child and/or unborn lives with the father check "yes," if not, check "no"

Family Size

This section asks for information about other family members who are not already listed on the application on pages A1 and/or A2. This information is needed to accurately determine the family size and program eligibility.

Family Size List **all** other family members who live in the home. Include children under 21, stepparents, and the spouse of any teenager or pregnant woman who lives in the home. Do **not** list aunts, uncles, nieces, nephews, or grandparents. *(For more information, see page 4.)*

	Name	Gender	Date of Birth	How is this person related to the person in ①?
㉖		☐M ☐F	____/____/____ mo day yr	☐Child ☐Boyfriend ☐Spouse ☐Stepchild ☐Girlfriend ☐Other _____
㉗		☐M ☐F	____/____/____ mo day yr	☐Child ☐Boyfriend ☐Spouse ☐Stepchild ☐Girlfriend ☐Other _____
㉘		☐M ☐F	____/____/____ mo day yr	☐Child ☐Boyfriend ☐Spouse ☐Stepchild ☐Girlfriend ☐Other _____

㉙ Is any person in the home pregnant? . . . . . ☐ Yes ☐ No

*If yes, who?*_____ *How many babies is she expecting?*_____ *Due Date:* ____/____/____ mo day yr

Questions 26 – 29

26–29. Family Size

- List all family members living in the home that have not yet been listed on the application. These members can include:
    - Children who already have health coverage
    - Children ages 19 to 21
    - Children who are away at school AND are claimed as tax dependents by their parents
    - Stepparents living in the home
    - The spouse of a teenager or pregnant woman living in the home
    - The father of the baby of a teenager living in the home
    - Boyfriends or girlfriends
    - Do NOT list aunts, uncles, nieces, nephews, or grandparents

NOTE: Do not list children who receive SSI/SSP or public assistance. They are not counted in the family size. See Chapter 4 (*Family Size and Income Determination*) for more information.

Gender

- Indicate the gender of each person listed

Date of Birth

- Enter the date of birth of each person listed as shown: Month/Day/Year

How is this person related to the person in (1)

- Check the box that best matches the relationship (child, step child, boyfriend, girlfriend, spouse, other) of the person listed to the person in Question 1
- If the relationship is "Other," write in the type of relationship

29. Is any person in the home pregnant?

- Indicate if anyone in the home is pregnant
- If "yes," indicate person pregnant
- List any family members who are pregnant. This could be a pregnant teen, parent or stepparent living in the home. This information is required because the unborn child is counted in the family size
- If pregnant women (over 18 years old) wish to apply for Medi-Cal, they may complete a separate application or apply directly at their local county Department of Social Services. Women who are late-term or have a high-risk pregnancy should apply directly at their local county Department of Social Services for a faster eligibility determination

How many babies is she expecting?

- Indicate the number of babies expected with this pregnancy. For example, if the pregnant woman is carrying twins, a two would be entered for this question. The pregnant woman will need to provide proof of the expected number of babies

Due Date

- If there is a pregnant woman applying for coverage, enter the expected date of delivery as shown: Month/Day/Year

Application Page A3

Family Income

This section of the application obtains information about family members' sources of income, how often income is received, and how much is the gross income.

The information in this section is used to determine the gross income, source of income and how often the income is received for each family member.

Family Income List the income of **every** person listed in this application. Include child support and spousal support **received**. *(Use a separate line for each source of income.)*

	Name of person with income *(Children who are in school do not have to list their income from a job.)*	Source of Income *(job, social security, pension, etc.)*	How often is income received? *(Weekly, biweekly, monthly)*	How much is the income? *(total gross income)*	Social Security Number *(Optional)*
30				$	
31				$	
32				$	
33				$	
34				$	

Questions 30 - 34

Name of Person with Income

- List the name of each family member with income
- Use a separate line for each source of income

REMINDER: Child support received is the CHILD'S income and must be listed with the CHILD'S NAME and NOT the parent's name. DO NOT list the income of people in the home who are not counted in the family size. The earned income of children over age 14 will only count if the child is not in school.

Source of Income

- List where the income comes from, such as work (give name of the employer, self-employment, etc.), Social Security, spousal support, or child support. See Chapter 4 (*Family Size and Income Determination)* for more information

REMINDER: People who receive public assistance, such as SSI/SSP, Cal WORKs and General Relief will NOT be included in the family size. However, this income must be listed and proof of income must be submitted. This income will not be counted but is needed by SPE to make sure these individuals are not counted in the family size. See Chapter 4 (*Family Size and Income Determination)* for more information.

How Often is Income Received?

- List how often the income is received:
    - Weekly (paid once a week)
    - Every Two Weeks (paid every other week)
    - Twice a Month (paid two times a month, e.g., the 15th and 30th)
    - Monthly (paid once per month)
    - Annually/yearly

How Much is the Income?

- List the gross income amount on the paycheck stub or other proof of income (before taxes or other withholdings). For example, if family members are paid weekly, list the amounts they are paid each week. Do not calculate the pay amounts to equal a monthly income. Each program will need to validate the income amount and the pay frequency stated on the application. Pay frequencies are calculated by the Programs using a multiplier of 4.33 or 2.167, etc. to determine the monthly income for each child

NOTE: If family members are using federal income tax returns to prove their incomes, enter "yearly" in the "How often is income received?" field. See Chapter 4 (*Family Size and Income Determination)* for more information.

Social Security Number

- Enter the Social Security numbers of the family members with incomes
- This information is OPTIONAL

Expenses

This section asks for information to determine the appropriate income deductions. Some deductions, such as the $90 work expense deduction and the $50 deduction for receiving child support or alimony per household (e.g., two persons receive child support they each receive $25 deduction), are not listed in this section. These deductions are given automatically based on the proof of income included with the application.

This section is divided into three parts

- Child Day Care or Disabled Dependent Care
- Court-Ordered Child Support
- Court-Ordered Spousal Support

If families do not make these payments, leave blank.

Expenses List the monthly expenses of the person in (1) and the people listed above.

(35) Child Day Care or Disabled Dependent Care

For *(child or dependent's name)*:_____ Age:_____ Amount paid:_____

For *(child or dependent's name)*:_____ Age:_____ Amount paid:_____

For *(child or dependent's name)*:_____ Age:_____ Amount paid:_____

(36) Court-ordered child support

Paid to:_____ Paid by:_____ Amount paid:_____

Paid to:_____ Paid by:_____ Amount paid:_____

(37) Court-ordered spousal support

Paid to:_____ Paid by:_____ Amount paid:_____

Questions 35 - 37

35. Child Care or Disabled Dependent Care

- List the names of the children or dependents that are receiving child or dependent care

Age

- List the ages of the children or disabled dependents

Monthly Amount Paid

- List total amount PAID PER MONTH for child/dependent care, even if it is more than the maximum deductions allowed. The maximum deduction depends on the age of each child:
    - Up to $200 per child under 2 years of age
    - Up to $175 per child age 2 and older
    - Up to $175 per disabled dependent

36. List the name of the child that receives the court-ordered child support

List the name of the person that pays the court-ordered child support

List the amount of the court-ordered child support paid

NOTE: Only COURT-ORDERED payments can be deducted.

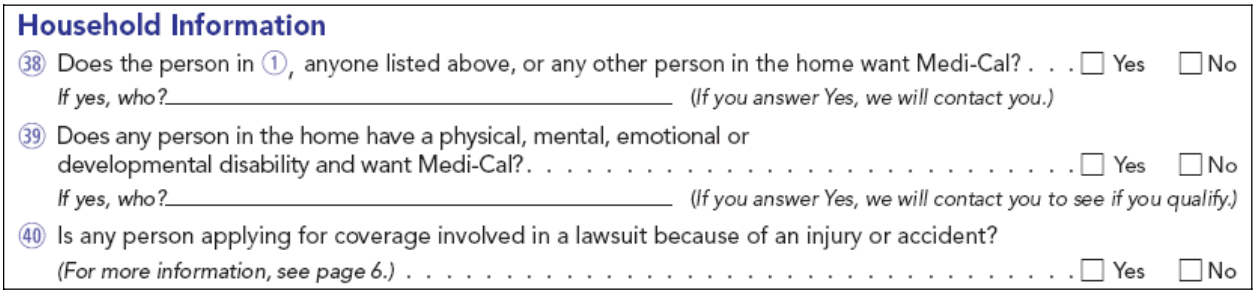
37. List the name of the person that receives the court-ordered spousal support

List the name of the person that pays the court-ordered spousal support

List the amount of the court-ordered spousal support paid

NOTE: Only COURT-ORDERED payments can be deducted.

Household Information


Household Information

38 Does the person in 1, anyone listed above, or any other person in the home want Medi-Cal? . . . ☐ Yes ☐ No
*If yes, who?*_____ *(If you answer Yes, we will contact you.)*

39 Does any person in the home have a physical, mental, emotional or developmental disability and want Medi-Cal? . . . . . ☐ Yes ☐ No
*If yes, who?*_____ *(If you answer Yes, we will contact you to see if you qualify.)*

40 Is any person applying for coverage involved in a lawsuit because of an injury or accident?
(For more information, see page 6.) . . . . . ☐ Yes ☐ No

Questions 38 – 40

38. Other Family Members Who Want Medi-Cal

- Indicate if the person listed (i.e. applicant) in (1), or any other person in the house want Medi-Cal
- If "yes," write the name of the person(s) who wants Medi-Cal. The family will be contacted by the local county Department of Social Services to obtain additional information required to determine if these family members qualify for Medi-Cal

39. Disabled person in the home

- If any of the family members in (1) or any person in the home have a physical, mental, emotional or development disability, check "yes." If not, check "no"
- If "yes," write the name of the person(s) with the disability

40. Lawsuit on Behalf of the Child or Pregnant Woman

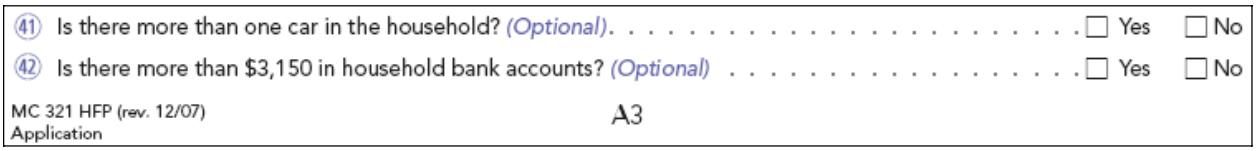
- If a lawsuit has been filed because of an accident or injury caused by another person or while at work, check "yes," if not, check "no." Medi-Cal will cover the services needed because of an accident
- If there is a legal settlement in your favor for an accident or injury and Medi-Cal covered your health care, you may have to pay Medi-Cal back for the services from the settlement

NOTE: The family does not pay Medi-Cal if the person does not receive a settlement.

Questions 41 – 42

This information is VOLUNTARY and DOES NOT affect a families' eligibility. The applicant only needs to indicate "yes" or "no."

Answers to these two questions may help the State of California claim federal funds for its health care programs.



41. More Than One Car

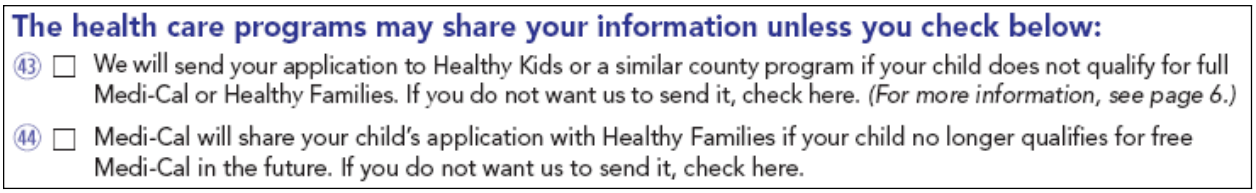
- If there is more than one car in the child and/or pregnant woman's household, check "yes," if not, check "no"

42. More Than $3,150 Cash in Bank Accounts

- If there is more than $3,150 cash in bank accounts in the children or pregnant woman's household check "yes," if not, check "no"

The health care programs may share your information unless you check below:

In this section the health care programs may share your information to see if you qualify for other programs unless you check the information in the following boxes.



Questions 43 – 44

43. Do not send to the Healthy Kids Program

- Check this box if the applicant does NOT wish to have their application sent to the Healthy Kids Program if their income does not qualify for no-cost Medi-Cal or the Healthy Families Programs

44. Do not share with the Healthy Families Program

- Check this box if the applicant does NOT wish to have their application sent to the Healthy Families Program if their income no longer qualifies for no-cost Medi-Cal

NOTE: For more information refer to page 6 of the application *"Other Questions."*

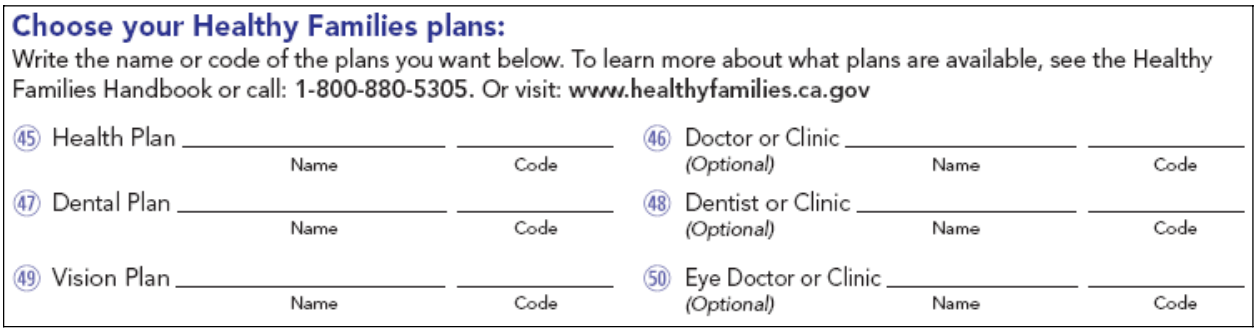
Application Page A4

Choose your Healthy Families plans:

This section collects the child's health, dental, vision plan and provider choices. Information about the available health, dental, and vision plans and providers is listed in the Healthy Families Handbook and on the Healthy Families website, www.healthyfamilies.ca.gov

If the applicant does not select health, dental, and vision plans for the children who are eligible for the Healthy Families Program, he/she will be contacted to select plans. If the applicant does not choose plans after they are contacted, plans will automatically be assigned for them by the Healthy Families Program.

The family is not required to select providers (doctor, dentist, eye doctor or clinic) for the children who are eligible for Healthy Families when applying. If the family does not select providers, the plans will assign the providers. See Chapter 7 (*Healthy Families Program)* for more information.



Choose your Healthy Families plans:

Write the name or code of the plans you want below. To learn more about what plans are available, see the Healthy Families Handbook or call: **1-800-880-5305**. Or visit: **www.healthyfamilies.ca.gov**

45 Health Plan _____ (Name) _____ (Code)

46 Doctor or Clinic *(Optional)* _____ (Name) _____ (Code)

47 Dental Plan _____ (Name) _____ (Code)

48 Dentist or Clinic *(Optional)* _____ (Name) _____ (Code)

49 Vision Plan _____ (Name) _____ (Code)

50 Eye Doctor or Clinic *(Optional)* _____ (Name) _____ (Code)

Questions 45 – 50

45. Health Plan and Code

- List the selected health plan name and code number

46. Doctor or Clinic Name and Code (optional)

- List the name and code for the doctor or clinic the applicant has chosen

47. Dental Plan and Code

- List the dental plan name and its code number for the plan the applicant has selected

48. Dentist or Clinic Name and Code (optional)

- List the name and code for the dentist or clinic the applicant has chosen

49. Vision Plan and Code

- List the vision plan name and its code number for the plan the applicant has selected

50. Eye Doctor or Clinic Name and Code (optional)

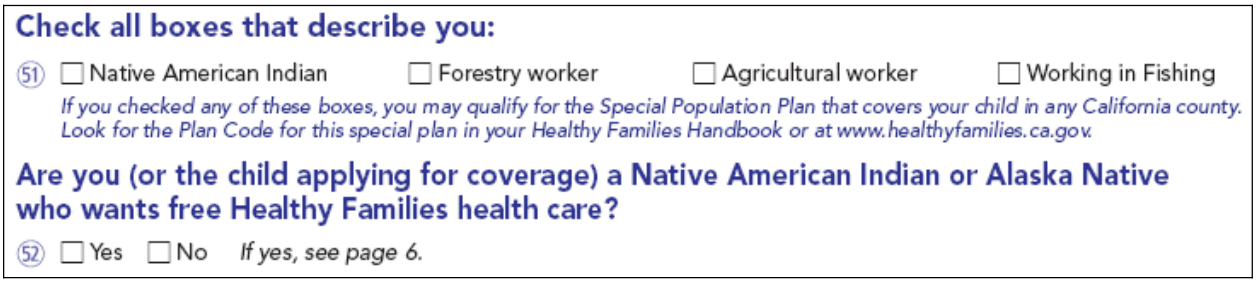
- List the name and code for the eye doctor or clinic the applicant has chosen

Special Population Plan and Premium Waiver

This is an optional plan available to American Indians and families working in seasonal or migratory jobs in agriculture, forestry or fishing. Families who qualify for the Special Population Plan are not required to select it. They may select any of the plans available in their county. The advantage of the Special Population Plan is that it is available statewide, and families will not need to change their children's plans when they move from county to county.

The Plan information is listed in the Healthy Families Handbook in the "Insurance Plans by County and Premium" section and the Healthy Families Program website at; www.healthyfamilies.ca.gov/English/choosing.html. This includes the plan combination code and premium information.

This section also gives the option for applicants that are Native American Indian or Alaska Native to request free health care.


Check all boxes that describe you:

51 ☐ Native American Indian ☐ Forestry worker ☐ Agricultural worker ☐ Working in Fishing

If you checked any of these boxes, you may qualify for the Special Population Plan that covers your child in any California county. Look for the Plan Code for this special plan in your Healthy Families Handbook or at www.healthyfamilies.ca.gov.

Are you (or the child applying for coverage) a Native American Indian or Alaska Native who wants free Healthy Families health care?

52 ☐ Yes ☐ No *If yes, see page 6.*

Questions 51 – 52

51. If the applicant is a Native American Indian, Forestry worker, Agricultural worker, or is Working in Fishing, check the appropriate box.

52. If the applicant or child applying for coverage is a Native American Indian or Alaska Native and they wish to have free coverage, select "yes" in the box above. If they do not wish to have free coverage, select "no" in the box above.

NOTE: Proof for the parent or the child if NAI/AN needs to be sent with the application or within two months of enrollment. For more information on what to send, see page 6 *"Other Questions"* of the application.

Application Page A4

Healthy Families Plan Disputes

Each plan has its own rules for resolving disputes about the delivery of services and other matters. Some plans say you must use binding arbitration for disputes; others do not. Some plans say that claims for malpractice must be decided by binding arbitration; others do not. If the plan you choose requires binding arbitration, you are giving up your right to a jury trial and cannot have the dispute decided in court. To find out more about how a plan resolves disputes, you can call the plan or look in the Healthy Families Program Handbook. Or go to: www.healthyfamilies.ca.gov

The Healthy Families Handbook lists which plans require Binding Arbitration in the "Answers to Commonly Asked Questions" section.

Healthy Families Plan Disputes

Each plan has its own rules for resolving disputes about the delivery of services and other matters. Some plans say you must use binding arbitration for disputes; others do not. Some plans say that claims for malpractice must be decided by binding arbitration; others do not. If the plan you choose requires binding arbitration, you are giving up your right to a jury trial and cannot have the dispute decided in court. To find out more about how a plan resolves disputes, you can call the plan or look in the HFP Handbook. Or go to: www.healthyfamilies.ca.gov.

Declaration and Signature

Declaration and Signature *(Required)*

I declare under penalty of perjury under California state law that I have read this application, the answers provided, and the documents enclosed and, to the best of my knowledge, they are correct and true. I have read and understand the Notices, and I am making the Declarations on page 7.

Applicant signs here: _____ Date: _____

Witness signs here *(If applicant signed with a mark)*: _____ Date: _____

Authorized Representative *(If any)*: _____ Date: _____

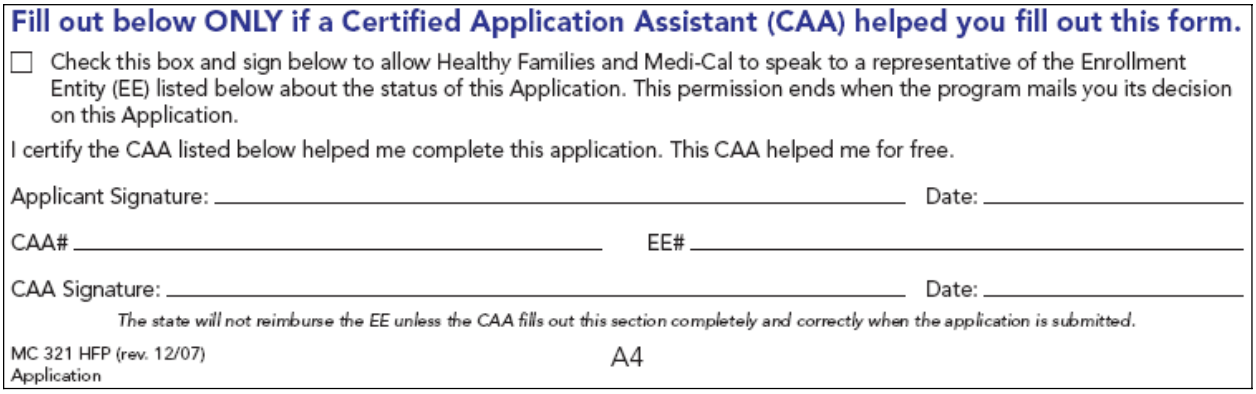
Signatures

- The applicant is required to sign and date his/her application on the signature line
- CAAs must explain to the applicant that he/she is certifying that the information is true and correct and that he/she can be prosecuted for information that is knowingly misrepresented on the application
- The signature of a witness is necessary if the applicant signs with a mark, such as an "X"
- An Authorized Representative is someone who can speak on behalf of the applicant. No proof is required to be submitted with the application to show that the person is the Authorized Representative. The county Department of Social Services and Healthy Families will contact the applicant if additional information is required

Application Page A4

Certified Application Assistance

The applicant signature, CAA Number, EE Number, and CAA Signature fields must all be filled out at the initial submission of the application in order to reimburse the Enrollment Entity. Reimbursement will be sent to the Enrollment Entity when the completed application results in the child(ren) being enrolled in the Healthy Families Program or granted Accelerated Enrollment (AE) Medi-Cal (see Chapter 6 of the CAA Reference Manual for more information on AE).



Fill out below ONLY if a Certified Application Assistant (CAA) helped you fill out this form.

☐ Check this box and sign below to allow Healthy Families and Medi-Cal to speak to a representative of the Enrollment Entity (EE) listed below about the status of this Application. This permission ends when the program mails you its decision on this Application.

I certify the CAA listed below helped me complete this application. This CAA helped me for free.

Applicant Signature: _____ Date: _____

CAA# _____ EE# _____

CAA Signature: _____ Date: _____

The state will not reimburse the EE unless the CAA fills out this section completely and correctly when the application is submitted.

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Check the box above if the applicant wishes to give permission to a representative of the Enrollment Entity to speak with the Healthy Families Program regarding the status of the application. This permission ends when the program mails the applicant the eligibility decision.

Application Instructions Page 7

Healthy Families and Medi-Cal Declarations and Privacy Notice

Healthy Families Notices

Declarations

I declare that each person I am applying for:

- Is a resident of California
- Is not in jail or in a mental hospital
- Is not eligible for Medicare Part A and Part B
- Is not eligible for any California Public Employees Retirement System Health Benefits Program(s) or is eligible for a California Public Employees Retirement Health Benefits Program, but the employer contribution for dependent(s) is less than $10.

I also declare that:

- All individuals listed on this Application will follow the rules of participation, the utilization review process and the dispute resolution process of the plans in which the individual is enrolled.
- I have read and understand the *Healthy Families Handbook*. I understand what it says about each health, dental and vision plan and the benefits they offer.
- I am applying for all of my children eligible for Healthy Families, unless they are already enrolled, or unless I am only applying for myself.
- I give permission to Healthy Families to check my family income, health coverage, immigration status of the people I am applying for, and all other facts on this Application Form.
- I agree to notify the program within 30 days of any change of address of any person applied for who is accepted into the program and any change in the applicant's billing address.

Privacy

The law requires you provide the information requested to apply for Healthy Families. (Title 10, CCR, § 2699.6600) The personal and medical information you provide will be used only to identify you and to administer the program. This means we will share your information with the agencies and plans you want to enroll in.

Citizenship and Immigration Information

The application asks you about your citizenship and immigration status. You must answer these questions. We use your answers to administer the program and to see if you are eligible. If you are a parent or guardian and are not applying for yourself, we will not share your immigration information with other agencies, including the immigration authorities. If you do not answer the questions, we may deny your application.

Ethnicity

Unless you are applying for benefits based on your Native American ancestry, you do not have to answer the questions about ethnicity.

Social Security Numbers

You do not have to provide your Social Security Number if you do not want to.

Access to Your Records

You have the right to access records maintained by the Managed Risk Medical Insurance Board that contain your personal information. To do so, contact:

Managed Risk Medical Insurance Board
Attn: HIPAA Coordinator
P.O. Box 2769
Sacramento, CA 95812-2769
(916) 324-4695

Medi-Cal Notices

Rights, Responsibilities and Declarations

I have the right to:

- Be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
- Ask for an interpreter.
- Ask for a fair hearing if I think a decision on my Medi-Cal case is unfair or wrong. I must ask for a hearing within 90 days after I get a "Notice of Action". To find out about Medi-Cal fair hearings, call toll-free 1-800-952-5253.

I have the responsibility to:

- Send in a status report when the county asks me to.
- Report any changes in the information I gave on this Application Form within 10 days.
- Let the county know if a family member applies for disability benefits; is in a public institution; or gets medical care for any accident or injury caused by another person.
- Cooperate if my case is reviewed.

I declare that each person I am applying for:

- Lives in California.
- Is not getting public assistance from outside California.
- Is not in jail, prison, or any other correctional facility.

I further declare that:

- I understand that as a condition of Medi-Cal eligibility, all rights to medical support and third party payments are automatically assigned to the State of California.
- If I am not eligible for this Medi-Cal Program, I understand I may qualify for other programs and have the right to apply for them.
- If I purposely do not give needed facts, or if I give false facts, I understand benefits may be denied or ended and repayment may be required. I may also be investigated for fraud.

Confidentiality

The information you give on this Application Form is private and confidential. It will only be disclosed if required by law. *(Welfare and Institutions Code Sections 10850 and 14100.2)*

Privacy

The law requires Medi-Cal applicants answer all questions on this application not marked optional. (Welfare & Institutions Code, § 14011 and Title 22, CCR regulations) The personal and medical information you provide will be used only to identify you and to administer the program. This means we will share your information with federal, state, and local agencies.

Citizenship and Immigration Information

If you are applying for benefits, you must answer the questions about citizenship and immigration status. If you are a parent or guardian and are not applying for yourself, you do not have to provide your immigration information. If you are applying for full-scope Medi-Cal, we will confirm your immigration status with Immigration (USCIS) only to see if you are eligible. We will not share your immigration information with Immigration or other agencies for any other reason. Your application will be incomplete if you do not answer these questions for persons applying and we may deny your application.

Social Security Numbers

Unless you are applying for emergency or pregnancy-related benefits only, you must provide your Social Security Number. (Welfare & Institutions Code § 14011.2 and Social Security Act §1137(a)(1)).

Access to Your Records

You have the right to access records maintained by the Department of Health Care Services that contain your personal information. To do so, contact your county health and human services or social services office.

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The Certified Application Assistant must review with the applicant the Healthy Families and Medi-Cal Declarations listed in this section.

The Applicant is Required to Make the Following Healthy Families Program Declarations Listed Below

The applicant declares that each person he/she is applying for

- Is a resident of California
  Children must be California residents to be eligible for Healthy Families
- Is not in jail or in a mental hospital
- Is not eligible for Medicare Part A and Part B
  Children eligible for Medicare Part A and Part B are not eligible for Healthy Families

- Is not a member of a family that is eligible for health benefits from the California Public Employees Retirement System Health Benefits Program(s) (CALPERS):

    - Children eligible for health benefits from CALPERS are not eligible for Healthy Families unless CALPERS pays less than $10 a month towards the children's benefits
    - Examples of employees who may be eligible for CALPERS are federal, state, or county employees, as well as school district employees

The applicant further declares that

- All individuals listed on this Application will follow the rules of participation, the utilization review process and dispute resolution process of the participating plans in which the individual is enrolled
- I have read and understand the Healthy Families Handbook. I understand what it says about each health, dental, and vision plan and the benefits they offer
  The handbook contains important information about eligibility, premiums, and other program details
- I am applying for all of my children eligible for Healthy Families, unless they are already enrolled, or unless I am only applying for myself
- I give permission to Healthy Families to check my family income, health coverage, immigration status of the people I am applying for, and all other facts on this Application Form
- I agree to notify the program within 30 days of any changes of address of any person applied for who is accepted into the program and any change in the applicant's billing address

Privacy Notice

The information in this section explains how the application information provided by the applicant will be used by the Healthy Families Program.

CAAs must review this section with the applicant

- The law requires you provide the information requested to apply for Healthy Families.

(Title 10, CCR, § 2699.6600) The personal and medical information you provide will be used only to identify you and to administer the programs. This means we will share your information with the agencies and plans you want to enroll in

Medi-Cal Rights, Responsibilities and Declarations

I have the right to

- Be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs
- Ask for an interpreter
- Ask for a fair hearing if I think a decision on my Medi-Cal case is unfair or wrong. I must ask for a hearing within 90 days after I get a "Notice of Action." To find out about Medi-Cal fair hearings, call toll-free 1-800-952-5253

I have the responsibility to

- Send in a status report when the county asks me to
- Report any changes in the information I gave on this Application Form within 10 days
- Let the county know if a family member applies for disability benefits; is in a public institution; or gets medical care for any accident or injury caused by another person
- Cooperate if my case is reviewed

I declare that each person I am applying for

- Lives in California
- Is not getting public assistance from outside California
- Is not in jail, prison, or any other correctional facility

I further declare that

- I understand that as a condition of Medi-Cal eligibility, all rights to medical support and third party payments are automatically assigned to the State of California
- If I am not eligible for this Medi-Cal Program, I understand I may qualify for other programs and have the right to apply for them
- If I purposely do not give needed facts, or if I give false facts, I understand benefits may be denied or ended and repayment may be required. I may also be investigated for fraud

Medi-Cal Confidentiality

- The information you give on this Application Form is private and confidential. It will only be disclosed if required by law (Welfare and Institutions Code Sections 10850 and 14100.2)

Application Declarations Page 7

Medi-Cal Privacy

- The law requires Medi-Cal applicants answer all questions on this application not marked optional. (Welfare & Institutions Code, § 14011 and Title 22, CCR regulations) The personal and medical information you provide will be used only to identify you and to administer the program. This means we will share your information with federal, state, and local agencies

Application Document Check Sheet Page 2

Here's how to apply:

Pregnant? *See page 5.*

1 Fill out the 4-page application.

If you do not understand a question, or do not have any of the documents, call: **1-800-880-5305**. Or, look for the information you need on pages 3–7.

2 Send us copies of income and expense documents.

(You may be able to use other documents not listed here.)

☐ **One document for each person living in the home who has a job:**

- A recent pay stub (from less than 45 days ago), ***or***
- A signed, dated statement from your employer showing your gross income and how often you are paid, ***or***
- Last year's federal income tax return.

☐ **One document for each person living in the home who is self-employed:**

- Last year's federal income tax form with Schedules C, C-EZ, or F, ***or***
- A signed, itemized profit and loss statement for the last 3 months. For a sample profit and loss statement, go to: www.healthyfamilies.ca.gov, then click on *Download Forms and Documents*.

☐ **If you have income from Disability, Pensions, Retirement, Social Security, Veteran's Benefits, Workers' Compensation, or Unemployment, send a copy of:**

- The award letter, check, **or** bank statement showing direct deposit for the most recent payment.

☐ **If you receive or pay child support or spousal support, send a copy of:**

- The court order, paycheck stub showing support deduction, receipts, or the monthly support check, ***or***
- A statement from the Department of Child Support Services or the person who pays support that lists: the amount of monthly support, who the support is for, who pays for it, and who receives it.

☐ **If you pay for child day care or disabled dependent care, send a copy of:**

- A cancelled check **or** receipt, **or** a signed statement from your child day care provider showing how much you pay each month.

3 Send citizenship or immigration documents for each person applying.

(Send this now or as soon as you can.)

☐ **Citizens or Nationals:** Send a copy of the birth certificate, passport, certificate of U.S. citizenship or naturalization or other proof of citizenship for each person applying. We may ask you for more information later.

☐ **Non-citizens:** Send proof of immigration status. Make copies of front and back sides of documents. Or send a receipt from Immigration (USCIS) showing that you have applied to replace a lost document.
Even if the person applying does not have immigration papers, you can still apply for Medi-Cal.

4 ☐ Send one document per household that proves California residency.

(You may be able to use other documents not listed here.)

- A pay stub that shows your address in California, ***or***
- California Driver's license or ID card from DMV, ***or***
- Rent receipt or utility bill, ***or***
- Proof of your child's enrollment in school.

5 Sign and Mail the Application *(The application is on pages A1-A4.)*

Mail your application and copies of the documents in the attached envelope. No stamps needed!
Mail it to: **Healthy Families/Medi-Cal, P.O. Box 138005, Sacramento, CA 95813-9984**

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Application Document Check Sheet Page 2

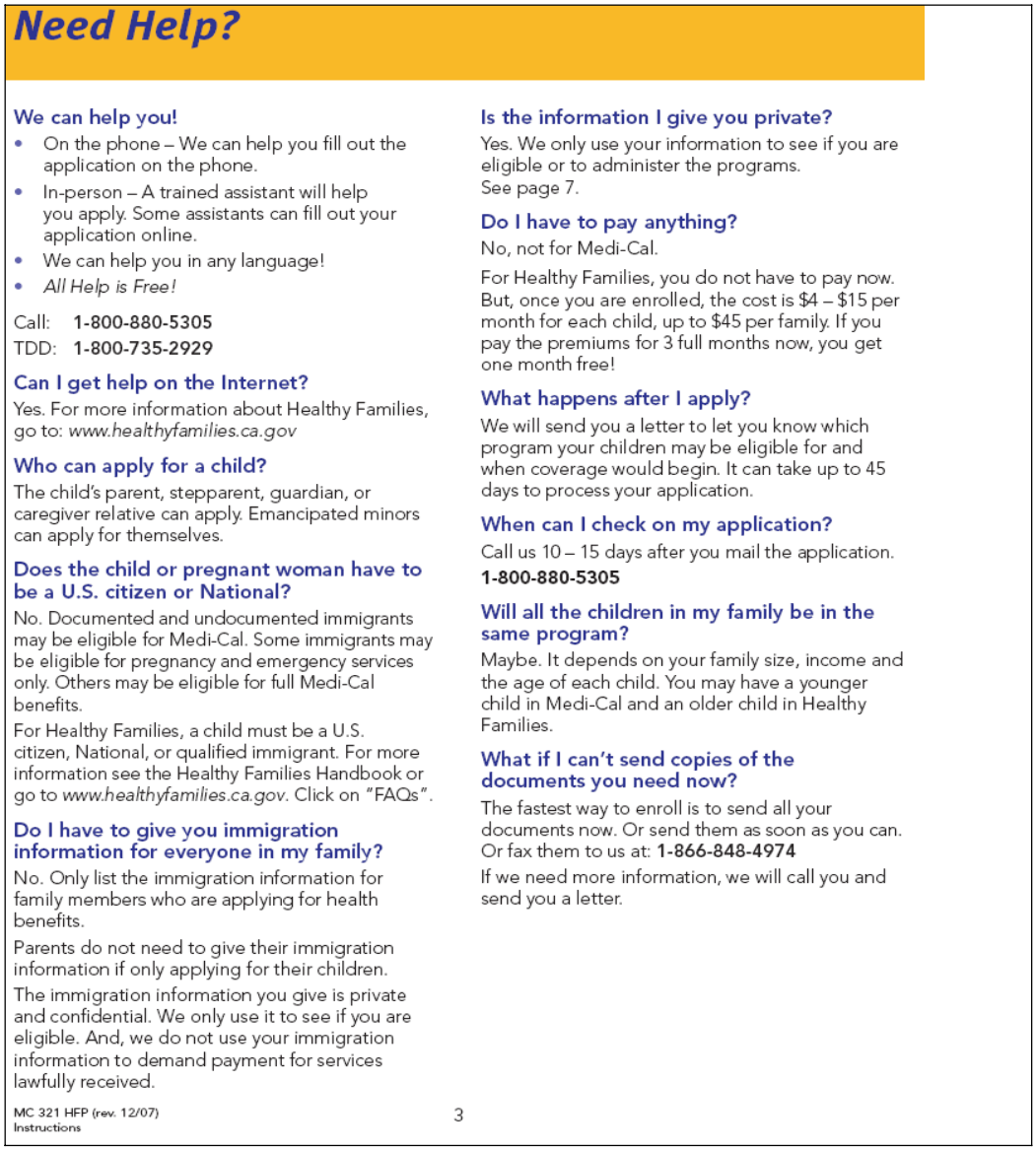
Here's how to apply

Certified Application Assistants (CAA) should review this important document check list with applicants. This check list details the five steps to submit a complete application. This will ensure the application is processed as quickly as possible without delays due to missing or incomplete information. It includes the steps to help applicants understand the different types of documents needed for income and expenses, citizenship and immigration, and where to send the complete application.

Applicants and CAAs should both use this document as a tool to ensure documents are submitted. These steps include

- Fill out the 4-page application
- Send us copies of income and expense documents
- Send copies of citizenship or immigration documents for each person listed in Question 8 on the application
- Send proof of California residency
- Sign and Mail the Application (The application is pages A1 – A4)

Frequently Asked Questions Page 3



Need Help?

We can help you!

- On the phone – We can help you fill out the application on the phone.
- In-person – A trained assistant will help you apply. Some assistants can fill out your application online.
- We can help you in any language!
- *All Help is Free!*

Call: **1-800-880-5305**
TDD: **1-800-735-2929**

Can I get help on the Internet?

Yes. For more information about Healthy Families, go to: *www.healthyfamilies.ca.gov*

Who can apply for a child?

The child's parent, stepparent, guardian, or caregiver relative can apply. Emancipated minors can apply for themselves.

Does the child or pregnant woman have to be a U.S. citizen or National?

No. Documented and undocumented immigrants may be eligible for Medi-Cal. Some immigrants may be eligible for pregnancy and emergency services only. Others may be eligible for full Medi-Cal benefits.

For Healthy Families, a child must be a U.S. citizen, National, or qualified immigrant. For more information see the Healthy Families Handbook or go to *www.healthyfamilies.ca.gov*. Click on "FAQs".

Do I have to give you immigration information for everyone in my family?

No. Only list the immigration information for family members who are applying for health benefits.

Parents do not need to give their immigration information if only applying for their children.

The immigration information you give is private and confidential. We only use it to see if you are eligible. And, we do not use your immigration information to demand payment for services lawfully received.

Is the information I give you private?

Yes. We only use your information to see if you are eligible or to administer the programs.
See page 7.

Do I have to pay anything?

No, not for Medi-Cal.

For Healthy Families, you do not have to pay now. But, once you are enrolled, the cost is $4 – $15 per month for each child, up to $45 per family. If you pay the premiums for 3 full months now, you get one month free!

What happens after I apply?

We will send you a letter to let you know which program your children may be eligible for and when coverage would begin. It can take up to 45 days to process your application.

When can I check on my application?

Call us 10 – 15 days after you mail the application.
1-800-880-5305

Will all the children in my family be in the same program?

Maybe. It depends on your family size, income and the age of each child. You may have a younger child in Medi-Cal and an older child in Healthy Families.

What if I can't send copies of the documents you need now?

The fastest way to enroll is to send all your documents now. Or send them as soon as you can. Or fax them to us at: **1-866-848-4974**

If we need more information, we will call you and send you a letter.

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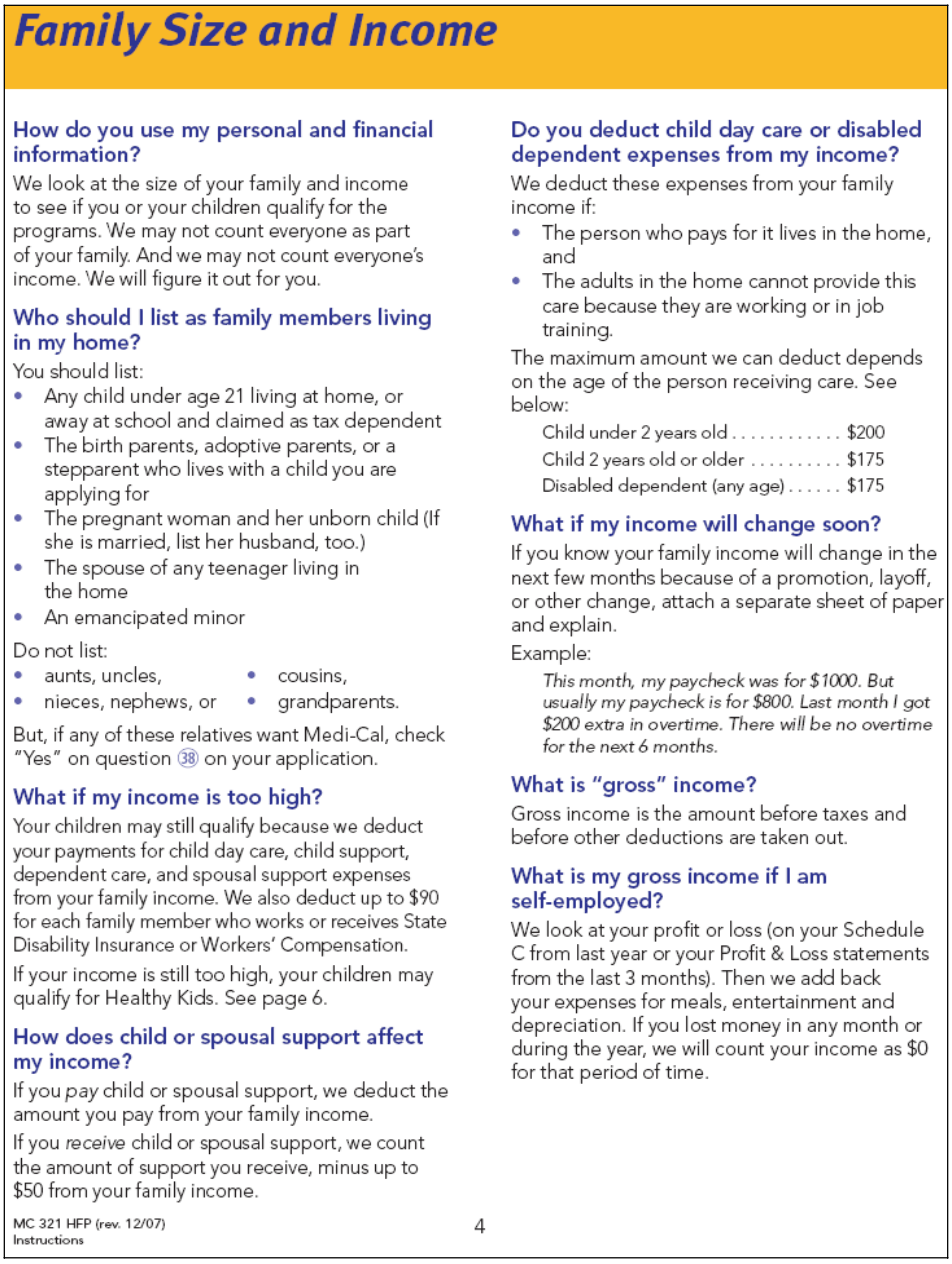
Need Help?

CAAs should be aware of the important information contained in each Frequently Asked Question (FAQ) section. The *"Need Help?"* section includes important information on the different ways to get assistance with your application. This includes telephone applications, referrals to CAAs, phone numbers and internet options.

It also includes clear information on commonly asked citizenship and immigration questions for children and women applying for coverage, as well as who in the household has to provide this information. This page informs CAAs and applicants on what to expect after an application is submitted.



Family Size and Income

How do you use my personal and financial information?

We look at the size of your family and income to see if you or your children qualify for the programs. We may not count everyone as part of your family. And we may not count everyone's income. We will figure it out for you.

Who should I list as family members living in my home?

You should list:

- Any child under age 21 living at home, or away at school and claimed as tax dependent
- The birth parents, adoptive parents, or a stepparent who lives with a child you are applying for
- The pregnant woman and her unborn child (If she is married, list her husband, too.)
- The spouse of any teenager living in the home
- An emancipated minor

Do not list:

- aunts, uncles,
- cousins,
- nieces, nephews, or
- grandparents.

But, if any of these relatives want Medi-Cal, check "Yes" on question (38) on your application.

What if my income is too high?

Your children may still qualify because we deduct your payments for child day care, child support, dependent care, and spousal support expenses from your family income. We also deduct up to $90 for each family member who works or receives State Disability Insurance or Workers' Compensation.

If your income is still too high, your children may qualify for Healthy Kids. See page 6.

How does child or spousal support affect my income?

If you *pay* child or spousal support, we deduct the amount you pay from your family income.

If you *receive* child or spousal support, we count the amount of support you receive, minus up to $50 from your family income.

Do you deduct child day care or disabled dependent expenses from my income?

We deduct these expenses from your family income if:

- The person who pays for it lives in the home, and
- The adults in the home cannot provide this care because they are working or in job training.

The maximum amount we can deduct depends on the age of the person receiving care. See below:

Child under 2 years old $200
Child 2 years old or older $175
Disabled dependent (any age) $175

What if my income will change soon?

If you know your family income will change in the next few months because of a promotion, layoff, or other change, attach a separate sheet of paper and explain.

Example:

This month, my paycheck was for $1000. But usually my paycheck is for $800. Last month I got $200 extra in overtime. There will be no overtime for the next 6 months.

What is "gross" income?

Gross income is the amount before taxes and before other deductions are taken out.

What is my gross income if I am self-employed?

We look at your profit or loss (on your Schedule C from last year or your Profit & Loss statements from the last 3 months). Then we add back your expenses for meals, entertainment and depreciation. If you lost money in any month or during the year, we will count your income as $0 for that period of time.

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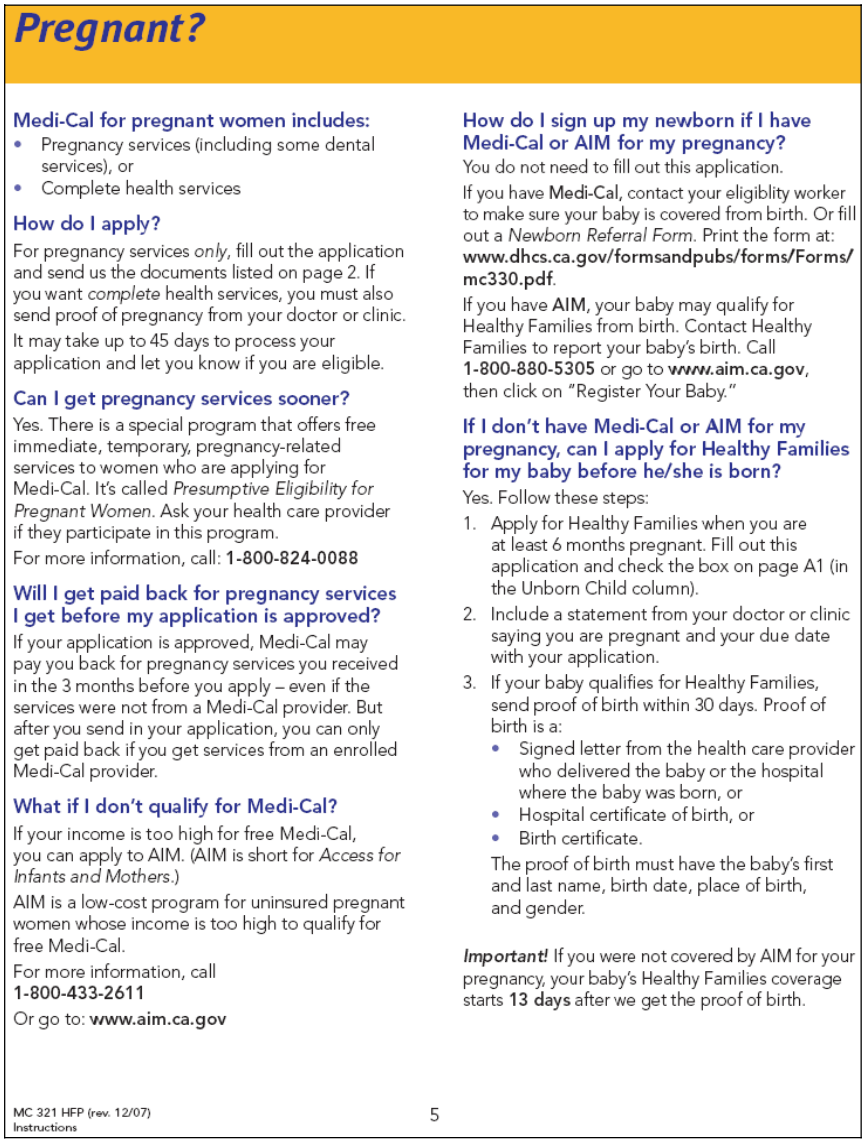
Family Size and Income

This section of the FAQs provides answers for who should be listed on the application, how income is calculated with dependent expenses and what to do when your income changes. Family size and income calculations need to be completely understood by the CAA and the applicant to understand which program the child/children or pregnant woman may qualify for.

CAAs and applicants need to review these FAQs during the application process.

Frequently Asked Questions Page 5



Pregnant?

Medi-Cal for pregnant women includes:

- Pregnancy services (including some dental services), or
- Complete health services

How do I apply?

For pregnancy services *only*, fill out the application and send us the documents listed on page 2. If you want *complete* health services, you must also send proof of pregnancy from your doctor or clinic.

It may take up to 45 days to process your application and let you know if you are eligible.

Can I get pregnancy services sooner?

Yes. There is a special program that offers free immediate, temporary, pregnancy-related services to women who are applying for Medi-Cal. It's called *Presumptive Eligibility for Pregnant Women*. Ask your health care provider if they participate in this program.

For more information, call: **1-800-824-0088**

Will I get paid back for pregnancy services I get before my application is approved?

If your application is approved, Medi-Cal may pay you back for pregnancy services you received in the 3 months before you apply – even if the services were not from a Medi-Cal provider. But after you send in your application, you can only get paid back if you get services from an enrolled Medi-Cal provider.

What if I don't qualify for Medi-Cal?

If your income is too high for free Medi-Cal, you can apply to AIM. (AIM is short for *Access for Infants and Mothers*.)

AIM is a low-cost program for uninsured pregnant women whose income is too high to qualify for free Medi-Cal.

For more information, call **1-800-433-2611**

Or go to: **www.aim.ca.gov**

How do I sign up my newborn if I have Medi-Cal or AIM for my pregnancy?

You do not need to fill out this application.

If you have **Medi-Cal**, contact your eligiblity worker to make sure your baby is covered from birth. Or fill out a *Newborn Referral Form*. Print the form at: **www.dhcs.ca.gov/formsandpubs/forms/Forms/mc330.pdf**.

If you have **AIM**, your baby may qualify for Healthy Families from birth. Contact Healthy Families to report your baby's birth. Call **1-800-880-5305** or go to **www.aim.ca.gov**, then click on "Register Your Baby."

If I don't have Medi-Cal or AIM for my pregnancy, can I apply for Healthy Families for my baby before he/she is born?

Yes. Follow these steps:

1. Apply for Healthy Families when you are at least 6 months pregnant. Fill out this application and check the box on page A1 (in the Unborn Child column).
2. Include a statement from your doctor or clinic saying you are pregnant and your due date with your application.
3. If your baby qualifies for Healthy Families, send proof of birth within 30 days. Proof of birth is a:
   - Signed letter from the health care provider who delivered the baby or the hospital where the baby was born, or
   - Hospital certificate of birth, or
   - Birth certificate.

   The proof of birth must have the baby's first and last name, birth date, place of birth, and gender.

Important! If you were not covered by AIM for your pregnancy, your baby's Healthy Families coverage starts **13 days** after we get the proof of birth.

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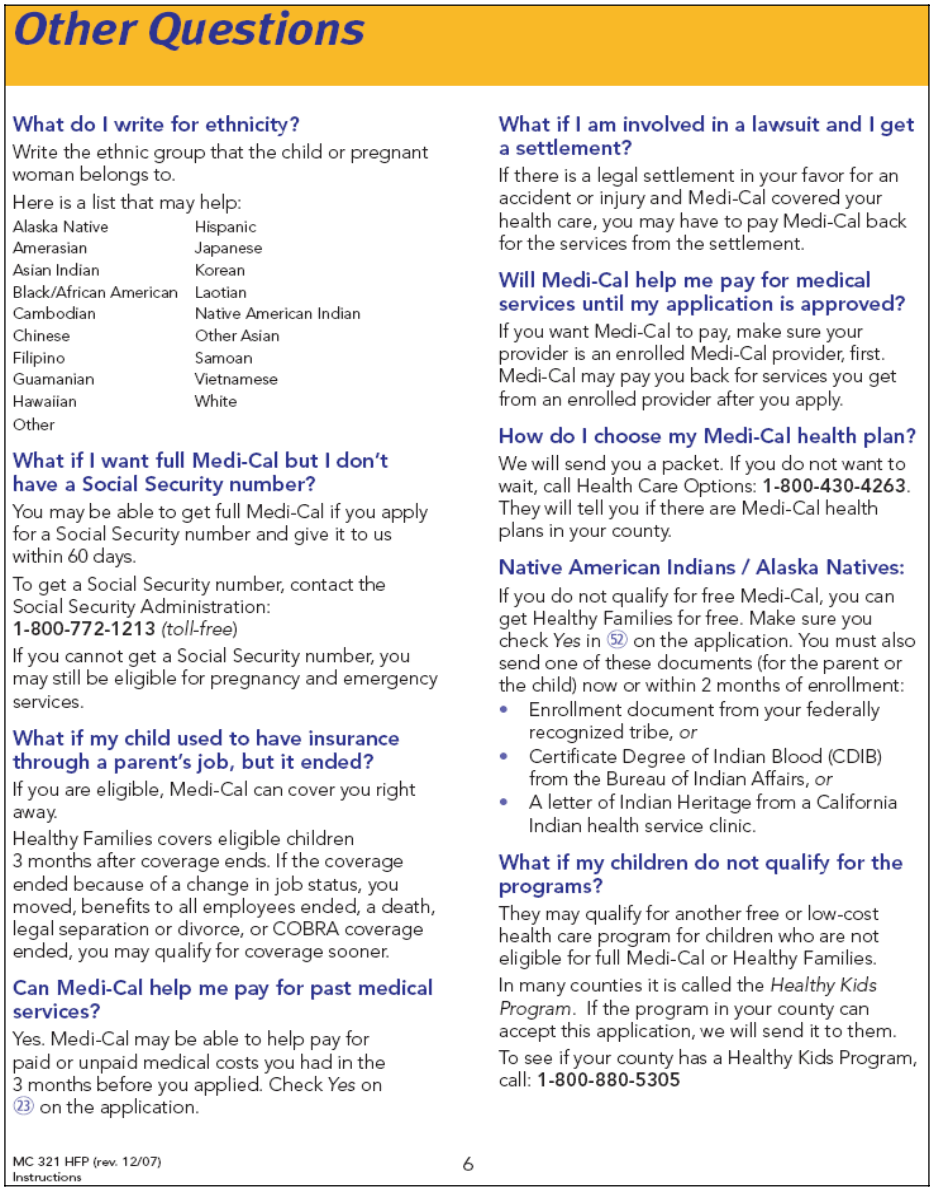
Pregnant?

This section of the FAQs assists CAAs and pregnant women with questions for pregnancy related health care and expenses related to pregnancy services. Important phone number and internet references are available for more assistance.

When pregnant women are seeking health care services it is important for them to know and understand the health care options for the unborn or newborn. This section offers answers to these questions.

CAAs should use this tool with applications for pregnant women and help the applicants understand pregnancy related resources.

Frequently Asked Questions Page 6



Other Questions

What do I write for ethnicity?

Write the ethnic group that the child or pregnant woman belongs to.

Here is a list that may help:

Alaska Native	Hispanic
Amerasian	Japanese
Asian Indian	Korean
Black/African American	Laotian
Cambodian	Native American Indian
Chinese	Other Asian
Filipino	Samoan
Guamanian	Vietnamese
Hawaiian	White
Other	

What if I want full Medi-Cal but I don't have a Social Security number?

You may be able to get full Medi-Cal if you apply for a Social Security number and give it to us within 60 days.

To get a Social Security number, contact the Social Security Administration: **1-800-772-1213** *(toll-free)*

If you cannot get a Social Security number, you may still be eligible for pregnancy and emergency services.

What if my child used to have insurance through a parent's job, but it ended?

If you are eligible, Medi-Cal can cover you right away.

Healthy Families covers eligible children 3 months after coverage ends. If the coverage ended because of a change in job status, you moved, benefits to all employees ended, a death, legal separation or divorce, or COBRA coverage ended, you may qualify for coverage sooner.

Can Medi-Cal help me pay for past medical services?

Yes. Medi-Cal may be able to help pay for paid or unpaid medical costs you had in the 3 months before you applied. Check *Yes* on (23) on the application.

What if I am involved in a lawsuit and I get a settlement?

If there is a legal settlement in your favor for an accident or injury and Medi-Cal covered your health care, you may have to pay Medi-Cal back for the services from the settlement.

Will Medi-Cal help me pay for medical services until my application is approved?

If you want Medi-Cal to pay, make sure your provider is an enrolled Medi-Cal provider, first. Medi-Cal may pay you back for services you get from an enrolled provider after you apply.

How do I choose my Medi-Cal health plan?

We will send you a packet. If you do not want to wait, call Health Care Options: **1-800-430-4263**. They will tell you if there are Medi-Cal health plans in your county.

Native American Indians / Alaska Natives:

If you do not qualify for free Medi-Cal, you can get Healthy Families for free. Make sure you check *Yes* in (52) on the application. You must also send one of these documents (for the parent or the child) now or within 2 months of enrollment:

- Enrollment document from your federally recognized tribe, *or*
- Certificate Degree of Indian Blood (CDIB) from the Bureau of Indian Affairs, *or*
- A letter of Indian Heritage from a California Indian health service clinic.

What if my children do not qualify for the programs?

They may qualify for another free or low-cost health care program for children who are not eligible for full Medi-Cal or Healthy Families.

In many counties it is called the *Healthy Kids Program*. If the program in your county can accept this application, we will send it to them.

To see if your county has a Healthy Kids Program, call: **1-800-880-5305**

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Other Questions

This section of the FAQs deals with questions 16, 18, 22, 23, and 52 of the application refer to this FAQ page for additional important information. CAAs review this page with applicants as the application is being completed. This page assists the applicants with a list of ethnic backgrounds so they can answer Question 16 of the application. If applicants have past medical expenses this page can assist with answers to commonly asked questions.

When children are not eligible for the Healthy Families Program or no-cost Medi-cal, they may be eligible for the Healthy Kids Program. Important contact information is listed on this page.